STATE OF CALIFORNIA
DEPARMENT OF INSURANCE
45 Fremont Street, 24th Floor
San Francisco, California 94105

SUPPLEMENT TO FINAL STATEMENT OF REASONS

INDIVIDUAL DISABILITY POLICY LOSS RATIO REGULATIONS

File Number: RH06092236
OAL Notice File Number: Z-06-0725-03
OAL Regulatory Action Number 06-1114-09S
December 28, 2006

The Final Statement of Reasons, dated November 14, 2006, is supplemented as follows:

1) Section 2222.11(h)

The discussion of section 2222.11(h), regarding a definition of "disease management expenses", found on page 3 of the Final Statement of Reasons, is replaced with the following:

Section 2222.11. Definitions:

New subdivision (h):

PURPOSE:
Based on consideration of comments received, the commissioner has determined that disease management expenses should, if the insurer wishes to do so, be included in the calculation of whether the benefits provided under a policy are reasonable in relation to the premium paid. Disease management expenses involve services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications using guidelines and patient self-management strategies.

NECESSITY AND RATIONALE:
Disease management services can improve the health of patients, reducing claims and the overall cost of health care. Because of these benefits, and to encourage the utilization of these services, the commissioner has determined that disease management expenses may be included as a factor in the determination of reasonability. The revised subdivision (h) provides a definition of "disease management expenses," based on Health & Safety Code section 1399.901. The definition describes the expenses as those incurred for services provided to patients to improve their overall health, and to prevent clinical exacerbations and complications. The definition states that the services must be cost-effective, which means that the optimum results are obtained for a given expenditure (this definition parallels the definition used, in a different regulatory context, in Cal. Code Regs., tit. 14, §58501, subd. (1)(6)). The commissioner has determined that, in order to be included as a factor, the disease management expenses claimed should yield optimum results for a given expenditure in order to maximize the benefits provided to the consumer per premium dollar. Therefore, in order to ensure that the funds spent on disease management expenses in fact yield a significant health benefit to the consumer, it is necessary

that those disease management expenses that are included as a factor in the determination of reasonability be cost-effective.

The definition also uses the term "guidelines," which is commonly understood in the health insurance and health care industries to refer to recommendations that have been systematically developed to assist health care providers and patients in making optimal health care decisions. The use of guidelines in health care is so well established that the federal Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services maintains a "National Guideline Clearing House." "Evidence-based" guidelines are guidelines developed based on objective evidence from professional literature and research studies. The commissioner has determined that a definition based on guidelines that required documented, objective evidence would best achieve the goal of improving the health of the insured while, at the same time, assuring that the expenses of disease management represent an actual benefit to the insured.

In addition to the use of evidence-based guidelines, the definition of "disease management expenses" includes patient self-management strategies. These strategies encompass a broad range of educational activities designed to teach patients how to monitor their health status, and make appropriate interventions. Examples of patient self-management strategies include teaching patients how to perform routine manual self-examination for certain cancers, or teaching patients with diabetes how to monitor their blood sugar levels, control their diet, administer insulin, and prevent complications. These patient self-management strategies promote health, patient independence and autonomy, prevent complications, and reduce health care costs. Because of the benefits that these strategies bring to both improve health and control costs, and to encourage insurers to provide education regarding patient self-management strategies, the commissioner has determined that it is appropriate and necessary that patient self-management strategies be included within the definition of "disease management expenses" for the purpose of this regulation.

1) Section 2222.19

The discussion of section 2222.19, "Filing Experience Data", found on page 10 of the Final Statement of Reasons, is replaced with the following:

Section 2222.19: Filing Experience Data:

PURPOSE

The original amendment proposed changes to this section delete obsolete references to policies with annual premiums of $7.50 or less, and policies issued on the industrial debit basis, as such policies are no longer sold. Also, the phrase "pursuant to footnote (5) of the accident and health policy exhibit" was deleted, as the referenced exhibit no longer has a footnote 5.

Comments received during the public comment period expressed concern that, effective in 2007, the Accident and Health Experience Exhibit to the Annual Statement will no longer identify experience by policy form, and so would not provide the information needed to demonstrate compliance with the standard of reasonability. (The Exhibit and the Annual Statement are forms

developed and revised by the National Association of Insurance Commissioners.) Accordingly, the revised regulation replaces the now-obsolete form reporting requirement with an updated and simplified report of loss ratios per policy form, supported by a statement by an actuary plus an optional schedule of disease management expenses if an insurer chooses to include such expenses in demonstrating compliance with the standard of reasonability.

NECESSITY AND RATIONALE

The purpose and rationale for the Commissioner's determination that it is reasonably necessary to amend this provision is that the clarity of the regulation is improved by discontinuing the use of an obsolete measurement method, and by instead substituting a replacement means by which compliance with Insurance Code section 10293 can be monitored.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

REVISED UPDATED INFORMATIVE DIGEST

A Revised Updated Informative Digest has been filed concurrently, as a separate document, with this Supplement to Final Statement of Reasons.

REVISED COMMENT PAGES

The attached pages of the "Summary and Response to Public Comments" section of the Final Statement of Reasons are supplemented as follows:

1) The attached page 82 replaces the existing page;
2) The attached response to the comment of Leanne Ripperger on page 148 replaces the existing response.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		and we tend to see product premium prices significantly higher than what we have here in California. Part of the other problem that they have back there is they have guaranteed issue marketplace in all three of those states. We don't here. But we also note that based on the regulations they have in those states, they don't have near the kind of creativity and product design in the marketplace that we have here in California. So very much a reduced number of choices.	
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 10		Even though California currently has not adopted the compatibility with Federal Rules for HSA tax deductibility, we still see a significant number of HAS products available for sale here in California, just based on the federal -- the benefits in the federal tax deductibility. One of the things that we think, and the agent community thinks, that in California has made our individual marketplace more vibrant has been the willingness of the carrier community to take the risk with new products. While we as agents sell these products and you go talk to folks and you ask them if they like the high deductible, their answer is no. But if you ask them if they would rather pay $1,000 a month as opposed to the 500 or 600 a month premium they are currently paying, they say no. So they have, in effect, spoken with their feet. They have chosen in a marketplace that offers both kinds of products to pick a higher deductible, at least benefit rich product.	The Commissioner respectfully rejects this comment, because the loss ratio supports a reasonable relationship between premiums and benefits, and so acts to moderate, rather than increase, premium increases. Also, the fact that a lifetime anticipated loss ratio takes into account variations in loss ratio over the lifetime of a product means that a reasonable loss ratio will not inhibit innovation, even if new products show a lower loss ratio amount in their early years.
Testimony of Steven Lindsay, CAHU at September 19, 2006 public hearing pp. 11-12		Now the problem is as the marketplace moves that way, when you work on a percentage basis, when you bring in less revenue, you have less money for overhead. And so that 30 percent gets significantly less when I have a $600 premium than when I have a $1,000 premium. And so on some level there may even be some perverse incentives in this kind of regulation to put richer products on the street in	The Commissioner respectfully rejects this comment, because the Commissioner has determined that competition within the marketplace will encourage efficiency to control overhead costs, so that products with lower premiums can operate with the higher proposed loss ratio.

COMMENTER	SECTION	VERBATIM COMMENT (All mistakes in text appear in original)	CDI RESPONSE
		(supplement to response to comment of Leanne Ripperger, page 148:)	
L38,C3, p. 98 Leanne Ripperger, Pacificare	2222.19	Finally, we would recommend that the Department consider implementing a deemer provision which would allow a health insurance carrier to certify that they have met the loss ratio standard in this regulation. This will streamline the regulatory filing process without eliminating the consumer protections included within this regulation.	The Commissioner respectfully rejects this suggestion. As understood by the Department, a "deemer" provision is one in which a filing is deemed approved within a specified time period unless the Department objects. The Commissioner rejects the proposal that compliance with loss ratio provision be deemed accepted unless an objection is made. The Commissioner also rejects the suggestion that compliance be demonstrated by a certification, without other data, because a certification alone would not provide the benefits of also obtaining the loss ratio data specified in the proposed regulation. The proposed regulation provides for a statement of compliance that lists policy forms and loss ratios, as well as a statement from a qualified actuary that the standards of reasonability have been met. This data will enable the Department to monitor compliance, and track the effectiveness of the amended regulation.